Welcome

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Meeting agenda

8:30 A.M.	Welcome, introductions
9:00	Agenda overview, commission charge and work process
9:40	Dialogue on work process
10:00	Briefing on the Michigan mental health system
11:30	Results of commissioner survey
12:00 P.M.	Lunch
1:00	Proposed guiding principles, framework for deliberations
1:30	Small group dialogue on principles/framework
2:30	Report out
3:15	Planning for next meeting
3:30	Public comment
4:00	Adjourn

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Flinn Foundation

- Donation to the commission

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Commission charge

- Identify and assess pressing issues and challenges and make recommendations to improve the public mental health system

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Work plan overview

February	Grounding, setting guiding principles
March–April	Public hearings; work groups developing recommendations
May	Refining recommendations
June–July	Preparing preliminary recommendations
August	Drafting report
September	Finalizing recommendations
October	Approving final report

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Meeting schedule

February 2	Lansing	8:30: A.M–4:00 P.M.
March 1	TBD	8:30 A.M–4:00 P.M.
March 29	TBD	8:30 A.M–4:00 P.M.
April 26	TBD	8:30 A.M–4:00 P.M.
May 24	TBD	8:30 A.M–4:00 P.M.
June 28	TBD	8:30 A.M–4:00 P.M.
July 26	TBD	8:30 A.M–4:00 P.M.
September 20	TBD	8:30 A.M–4:00 P.M.
October 25	TBD	8:30 A.M–4:00 P.M.

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Roles and responsibilities

- Commission members
  - Commit significant time and energy
  - Attend one public hearing
  - Balance individual passions, consumers' best interests
  - Select key issues, identify best practices
  - Communicate mandates and limits to stakeholders
  - Develop and recommend achievable, measurable actions
  - Provide considerations for implementation

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Roles and responsibilities

- Commission Chair and Vice Chair
  - Facilitate all meetings of the full commission
  - Participate in project management team meetings
  - Assist the commission in selecting key issues, determining work groups
  - Facilitate consensus among members on recommendations for final report
  - Serve as spokespersons for the commission

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Roles and responsibilities

- Project management team (PMT)
  - Present charge, roles, framework, background for work plan
  - Manage work plan; develop meeting agendas, summaries
  - Prepare materials, manage communications
  - Develop and manage engagement of public/stakeholders
  - Propose charges, provide staffing for work groups
  - Provide facilitation support

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Roles and responsibilities

- Michigan Department of Community Health (MDCH)
  - Assist in preparation of PMT meeting agendas
  - Identify/provide background materials
  - Manage commission Web-based communication, public website
  - Handle media relations, communications
  - Manage four public hearings and summarize testimony
  - Staff half of the commission work groups
  - Review the final report of the commission

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Roles and responsibilities

- Public Sector Consultants (PSC)
  - Assist in preparation of PMT meeting agendas
  - Develop, maintain commission work plan
  - Draft agendas for/summaries of commission meetings
  - Propose method/structure for online public commentary
  - Distribute commissioner correspondence
  - Manage commission meeting logistics
  - Staff half of the commission work groups
  - Write the commission's final report

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Protocols

- Meetings
- Reaching consensus
- Public comment
- Communication

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Meeting protocol

- Meetings begin on time
- Alternates not permitted (voting members)
- Action by majority vote of members
- Meeting summaries will be posted on the website (commissioners' comments not attributed in summaries)
- Meetings, documents are public

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Reaching consensus

- Goal: reach consensus on all final report recommendations
- Majority vote if necessary
- No minority reports

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Public comment

- Four public hearings throughout the state (March)
- Public comment at commission meetings:
  - written comments submitted in advance
  - select number invited to speak, by comment relevance
- Public comment accepted in writing to PSC
- Public comment solicited through website
- All comments will be reviewed and considered; no personal replies

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Communication protocol

- Chair and Vice Chair serve as commission spokespersons
- Legal, legislative, and media contacts referred to the Michigan Department of Community Health

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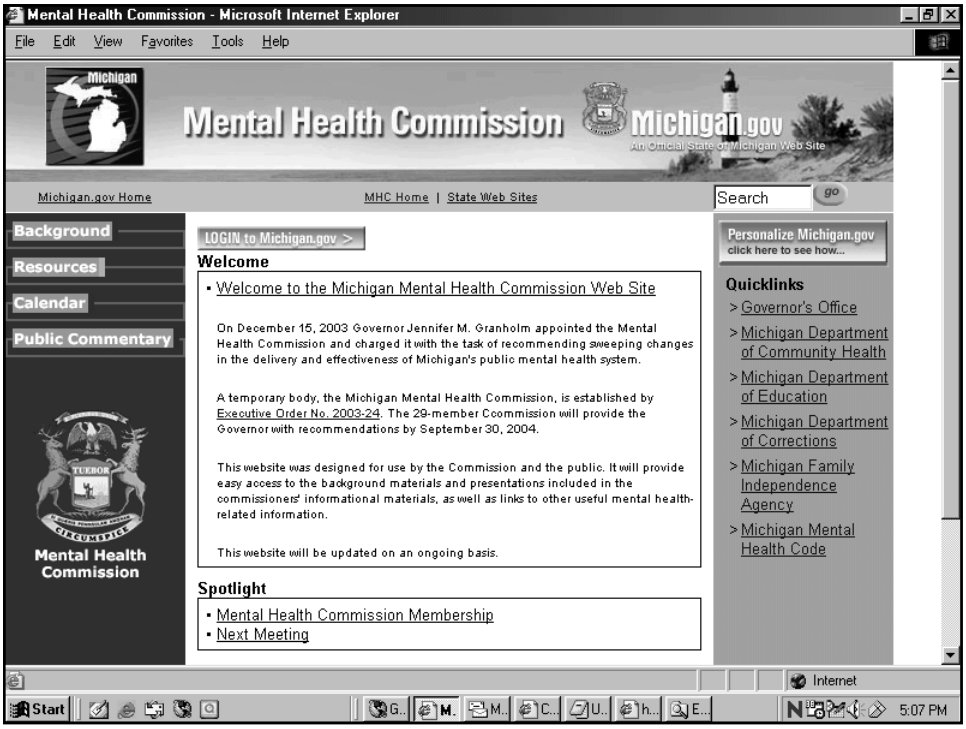

www.michigan.gov/mentalhealth

- Calendar of commission events, meetings and hearings
- Materials presented to the commission
- Public comment feature
- Links to an array of reference materials
- Comprehensive information on the Michigan mental health system and services

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Commissioner dialogue

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Briefing on the Michigan Mental Health System

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Organization of mental health services

- Institutional era
  - Rationale for the establishment of institutions
    - Humane inclinations and motives
    - Industrialization and urbanization
  - "The Sleep of Reason Produces Monsters"—Goya
    - Massive size, overcrowded, underfunded, understaffed
    - Pessimism about recovery and discharge
    - "Institutionalism" (passivity/dependency) and isolation
    - Patient mix
  - Peak national census: 559,000 (1955)
    - Over ½ of hospital beds in U.S. occupied by persons with mental illness

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Seeds of change

- Media exposé of institutional conditions
- Experience of war-time psychiatry (WWII)
- National Institute of Mental Health (1949)
  - Leadership at a national level on brain research, mental illness, and mental health
- Introduction of chlorpromazine (drug therapy)
- Innovations in hospital milieu therapy
- Mental Health Study Act of 1955
  - Joint Commission on Mental Illness and Health
- *Action for mental health* (1961)

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Action for Mental Health (1961)

- "The objective of modern treatment of persons with major mental illness is to enable the person to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all services to mental patients, and the various methods of achieving rehabilitation should be integrated into all forms of services…"
  - Joint Commission on Mental Health and Illness: A*ction for Mental Health*

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Further federal developments

- Community mental health centers legislation (1963)
  - Facility construction grants
  - Staffing grants
  - Core services
- Medicaid (1965)
  - Institution for Mental Disease (IMD) exclusion
- *Crisis in Child Mental Health* (1969)
  - Second report of the Joint Commission on Mental Health and Illness
- Supplemental Security Income Program (1972)

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Developments in Michigan

- Department of Mental Health (DMH) established (1945)
- State hospital census peaks at 20,413 (1957)
- Society for mental health study committee (1959)

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Developments in Michigan

- Act 54 (Community Mental Health Services Act): "Increasing numbers of persons afflicted with psychiatric disorders require care and treatment in mental institutions. The social and economic losses caused by these costly infirmities are a matter of grave concern to the people of the state. This act is designed to encourage the development of preventative, rehabilitative and treatment services through new community mental health programs and the expansion of existing community services."
- 1967 state psychiatric hospital census is 14,525
  - Expansion of state children's psychiatric hospital capacity

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Emerging problems: Deinstitutionalization

- Three components of deinstitutionalization
  - Discharge of persons residing in psychiatric hospitals to alternative community settings and services
  - Diversion of potential new admissions
  - Development of special services, programs, and support arrangements in the community to assist noninstitutionalized persons with mental illness
    - Organization, financing, and core services of community care

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Emerging problems: Deinstitutionalization

- Slow progress in third component—growth of alternative community services
- Unanticipated situations and conditions

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Federal response to emerging problems

- GAO Report to the Congress (1977)
  - Returning the mentally disabled to the community: government needs to do more
    - o "Mentally disabled persons have been released from public institutions without (1) adequate community-based facilities and services being available or arranged for and (2) an effective management system to make sure that only those needing inpatient or residential care were placed in public institutions and that persons released received needed services."
- NIMH: Community Support Program (1978)
- President's Commission on Mental Health (1978)
- GAO Report on Mental Health Care in Jails (1980)

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Michigan's response: Statutory change

- Mental Health Code (P.A. 258 of 1974) key provisions
  - Departmental (DMH) responsibilities (section 116)
    - o "the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state."
    - o "it shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county."

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Michigan's response: Statutory change

- Mental Health Code (P.A. 258 of 1974) key provisions
  - Funding arrangements and match
  - Priority populations
  - Core minimum services
  - Civil committee reforms
  - Recipient rights and protections
    - Least restrictive environment

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Michigan: New problems, new solutions

- GAO Report on Community Placement in Michigan (1977)
- Rights investigations at state facilities
- Establishment of standards for CMH boards (1977)

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Michigan: New problems, new solutions

- Governor's Committee on Unification of the Public Mental Health System (1979)
  - Committee report: *Into the 80s*
    - Committee recommends: "establishing a single point of responsibility for voluntary and involuntary entry into Michigan's public mental health system, for determination and oversight of the services it provides, for system exit, and for the resources that support service delivery. That single point of responsibility is to be located in the community. It is designated as a local mental health authority encompassing one or more counties."

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Michigan: MH system model in the 1980s

- Paradigm for organization, financing, and services
  - Use of substate entities (county-sponsored CMHs)
  - Full management concept
  - CMH as single entry/single exit to public system
    - Relationship with state psychiatric hospitals
    - Use of community inpatient units

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Michigan: MH system model in the 1980s

- Paradigm for organization, financing, and services
  - Financing structure and incentives
    - Trade-off dollars
    - Match rules
    - Introduction of Medicaid services and reimbursement
  - State-county partnership (relational contracting)
  - Continuum of care concept (core services; model programs)

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Michigan: MH system model in the 1980s

- Paradigm for organization, financing, and services
  - Community consultation, prevention, early intervention services
  - Respect for diversity
  - Priority populations and specially targeted groups
  - Strong rights protection

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1980s: Reports

- Report of the child mental health study group
- Report on community placement (mental health advisory council)
- Reports from the mental health and aging advisory group
- Report on mental disability prevention in Michigan
- Quality of care task force report

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1980s: Plans, initiatives, and concerns

- Plans
  - *Long-range plan for the mental health service delivery system*
- Initiatives
  - 1989 state hospital census (3,430 adults; 360 children)
  - Program developments (assertive community treatment, psychosocial rehabilitation, consumer-run services, children's diagnostic & treatment centers, infant mental health, etc.)
- Concerns: new cohort of seriously mentally ill

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Changing federal stance in the 1980s

- Mental Health Systems Act
  - Passed in 1980
  - Repealed in 1981
- Medicaid and SSI restrictions
- New federalism
  - Block grants
    - Community Mental Health Block Grant (1981)
    - State Mental Health Planning Act (1985)

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Changing federal stance in the 1980s

- Response to problems
  - Child & Adolescent Service System Program (CASSP)
  - Protection & Advocacy for the Mentally Ill (PAIMI)
  - McKinney Homeless Act
  - OBRA 1987: nursing home screening and treatment

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1990s: Shifting direction in the new decade

- FY 1990–91: recession and state budget deficit
- State hospital closures: 1991–97
  - Six state adult hospitals, five state children's hospitals
  - Community placement problems
    - DMH/DSS Task Force (1992)

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1990s: Shifting direction in the new decade

- New paradigm for MH system proposed
  - *Delivering the Promise: An Enhanced Model for Michigan's Public Mental Health System* (1992)
- A widening divide on the direction of state mental health policy

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Engulfed by larger national currents

- Debate over national health care reform
  - Failure of the Clinton plan for national restructuring
  - Private sector initiatives to restructure health care follow
    - Growth of managed care
- New levels and models of system integration proposed
  - Children's services: coordination and collaboration
  - Mental health & substance abuse integration
  - Primary care & mental health/substance abuse integration

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Engulfed by larger national currents

- New proposals for organization, financing, and service delivery arrangements in the public sector
  - Reinvention, competition, and privatization
  - Local public authorities, consolidated funding, and managed care
  - Challenges to the continuum of care concept
  - Consumerism and empowerment
  - Practice guidelines, quality, outcomes, performance, and accountability

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Public system: Grappling with uncertainty

- Key questions
  - What models or approaches to organizing, financing, and designing mental health services best facilitate improved outcomes and health status for adults and children with serious mental illnesses?
    - What are the constraints, limitations, or impediments to these models?
  - What services, treatments, and supports are the most effective in promoting positive outcomes for adults and children with serious mental illness?

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Public system: Grappling with uncertainty

- Service system research
  - Approaches to counter fragmentation and inefficiency
  - Broader service system integration proposals
- Service intervention research
  - Evidenced-based practices
  - Service/treatment integration strategies

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1990–97 dynamics of state/national trends

- Diminishing role of the state mental health authority
  - Dominance of state Medicaid agencies in policy and funding
- Rising interest in cost-containment strategies
  - Medicaid managed care

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1990–97 dynamics of state/national trends

- Escalating state-local tensions
  - Further devolution/decentralization of authority/funding
    - o Facility closures/transfer of residual state obligations to CMH
  - From partners to vendors
  - Competition and privatization threats
  - Disparate eligibility/services/funding/regulations
    - o Mental health code
    - o Federal grants and Medicaid
- Demand for measurement systems
  - Quality, accountability, performance, outcomes

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State changes: Revisions to MH code

- System organization changes
  - Mental health authorities
    - Preparation for managed care
- Value-based changes
  - Consumers and family members on CMH boards
  - Person-centered planning process requirement
    - Established statutory right for all individuals served through the public specialty service system to have their individual plan of service developed through a person-centered planning process

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State changes: Creation of DCH

- Combines DMH, Public Health, Medicaid, Aging

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Taking the leap of faith: Managed care

- States mimic private sector initiatives to control rising Medicaid costs
  - Medicaid managed care, capitation, and risk
    - Uncertainty about the effect of these arrangements on public mental health consumers, services, organizations

      But

    - More than 60% of CMH funds tied to Medicaid

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Taking the leap of faith: Managed care

- States mimic private sector initiatives to control rising Medicaid costs

  - Question is not **if** CMH Medicaid specialty services and funds will be moved into managed care
  - Question is **when** and **who** will manage the services and funds
    - Proposals from large behavioral managed care companies

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Medicaid managed specialty services

- Fending off alternative organization and financing plans
- The hope:
  - Unified local management of specialty mental health services
  - Single contract links multiple policies, programs,and payments

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Medicaid managed specialty services

- The implications
  - CMHSPS become “prepaid health plans” to manage Medicaid
    - Medicaid: entitlement/defined benefit
    - GF/GP: defined contribution
- The federal waiver
  - 1915(b) waiver
    - Deviation from federal procurement requirements
  - Waiver approved in June 1998; implemented in October 1998

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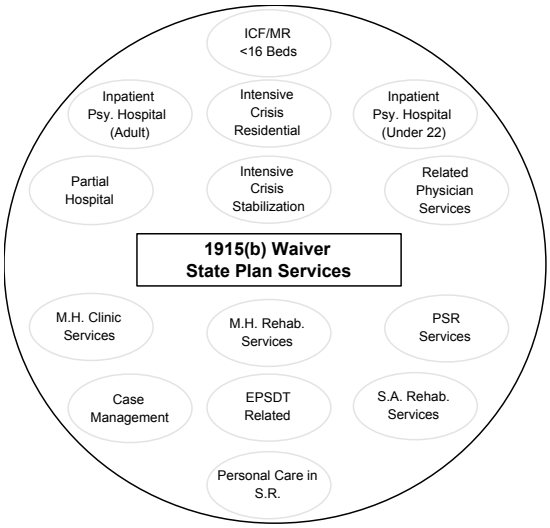
1915(b) waiver: State plan services



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Managed care challenges: 1998–2003

- Capitation funding struggles and controversies
  - SFA report
- Performing new administrative activities
  - Administrative duties and cost (addition of PHP functions)
  - Variations in managerial sophistication and structure
  - Federal regulatory framework (Balanced Budget Act of 1997)

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Managed care challenges: 1998–2003

- Changes in service system orientation
  - From community model to health plan model
- State-local relations
  - Competition and privatization threat—regionalization
  - Difficulty maintaining characteristics of a relational contract

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From community model to health plan model

Features	Community Model	Health Plan Model
Orientation	Community or Catchment Area	Health Plan
Major Source of Funding	State and/or Local Government	Federal Government
Primary Method of Payment	Grants or Contracts	Fee-for-Service or Capitation
Chief Governmental Authority	State Mental Health Authority	State Medicaid Agency or CMS
Attitude Toward Providers	Non-Competitive: Maintains stable network of publicly oriented specialty providers (safety net); little support for non-specialty or non-network providers	Competitive; no special effort to ensure longevity of any individual provider; little distinction between specialty and general providers
Attitude Toward Consumers or Beneficiaries	Priority Populations; Consumers receive services on the basis of providers determination of need and/or ability to pay	Beneficiaries have an entitlement to services subject to coverage limitations and determinations of medical necessity
Methods of Controlling Expenditures & Rationing Services	Supply based; uses bed limits, service slots and waiting lists	Demand-based; uses benefit limits, utilization management, and determination of medical necessity
Primary Focus of Data Collection and Organization	Provider	Beneficiary
Most Likely Underserved Populations	Persons who do not have serious disorders or who seek services outside of state maintained specialty provider network	Persons without Health Plan Coverage

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While we grappled with managed care …

- Consumed by organizational, financing, and regulatory challenges
- Attention/effort diverted from other issues
  - Mentally ill and the criminal justice system
  - Mental health needs of children in the child welfare and juvenile justice systems
    - Children with multisystem involvement
  - Decline of prevention and early intervention services
  - Lack of affordable, appropriate housing

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While we grappled with managed care …

- Service innovation and dissemination languishes
  - Departmental personnel and training resource diminish
    - Hinders dissemination of evidence-based practice and attention to emerging issues (co-occurring disorders)
    - Federal Block Grant provides only funding source for innovation

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But some gains realized

- Greater emphasis on consumer participation
- Guiding principles emerge
  - Community integration (ADA and the Olmstead decision)
  - Recovery paradigm in adult services
  - Strength-based, family-centered, ecological focus for children's services
- CMHSPS: certification and/or accreditation requirement
- System funding: retained saving and reinvestment in services

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But some gains realized

- Use of new medications (atypical antipsychotic drugs; SSRIs)
- Monitoring and improvement processes
  - Development of quality assessment and improvement strategies
  - Implementation of performance indicator system
  - Improvement data integrity
  - DCH site visit protocol
- Successful articulation of the rationale for public governance and management of mental health services

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The public mental health system today

- Four state adult state psychiatric hospitals
- One state children's psychiatric hospital
- Forensic center and prison mental health services

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The public mental health system today

- Community mental health services programs
  - 46 CMHSPS covering 83 counties
    - Responsible for mental health and developmental disabilities
    - All county-sponsored governmental entities
  - Different entity forms
    - Agency (of county government)
    - Organization (formed through Urban Cooperation Act)
    - Authority (special purpose governmental units)

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The public mental health system today

- CMHSPS (18) are "prepaid inpatient health plans" (PIHP)
  - Qualifications for managing Medicaid services on a risk basis
  - Standalone PIHPs and affiliation arrangement PIHPs

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System mandates, mission, operations

- Mandates: constitutional provisions and statutory base
  - Mental health code
- Federal considerations: ADA and the Olmstead decision
- Mission, guiding principles, strategic vision
- Department of Community Health structure
  - Major departmental administrations and matrix concept

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System mandates, mission, operations

- Mental health administration within the department
  - Hospitals, centers, forensic/prison mental health services
  - Community services
    - Serving two masters
      - Mental health code; state issues and priorities
      - Medicaid waiver and federal requirements
  - Office of recipient rights

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Funding for state operations

- Mental health/substance abuse administration
  - $9,135,900
    - Reduced by executive order
- State hospitals, centers, forensic, prison MH
  - $259,394,600

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Contracting and funding for CMHSPS

- Contracting with CMHSPS
  - Medicaid managed care contract with 18 PIHPs
    - Federal regulatory framework (contract requirements)
  - General fund contract with 46 CMHSPS
- Funding: major sources
  - Medicaid mental health services: $1,372,625,900
    - Capitation payments
  - CMH non-Medicaid services: $328,394,100
  - Adult benefits waiver: $40,000,000
  - Purchase of service (state facilities): $97,115,800
  - Federal mental health block grant: $13,000,000
  - MiChild (MH benefit): $1,309,550 (federal share)

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Data reporting & performance measures

- Demographics
- Services
- Costs
- Boilerplate report requirements
- HIPAA implementation
- Quality management system
  - Medicaid waiver requirements
- Performance indicator system
- Site visit process

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Number of Individuals Served in Michigan's Public Mental Health System by Eligibility Category

(Click on eligibility category for numbers of children and adults served)

Fiscal Year	Individuals with Mental Illness		Individuals with a Developmental Disability		Dual Diagnosis		Missing or Unknown		Total Served	
	N	%	N	%	N	%	N	%	N	%
1999	172,697	84.0%	26,435	12.9%	---	---	6,427	3.1%	205,559	100%
2000	151,084	79.3%	30,154	15.8%	---	---	9,170	4.8%	190,408	100%
2001	135,964	73.1%	33,199	17.9%	5,953	3.2%	10,868	5.8%	185,984	100%
2002	155,300	79.4%	25,725	13.2%	6,260	3.2%	8,267	4.2%	195,552	100%

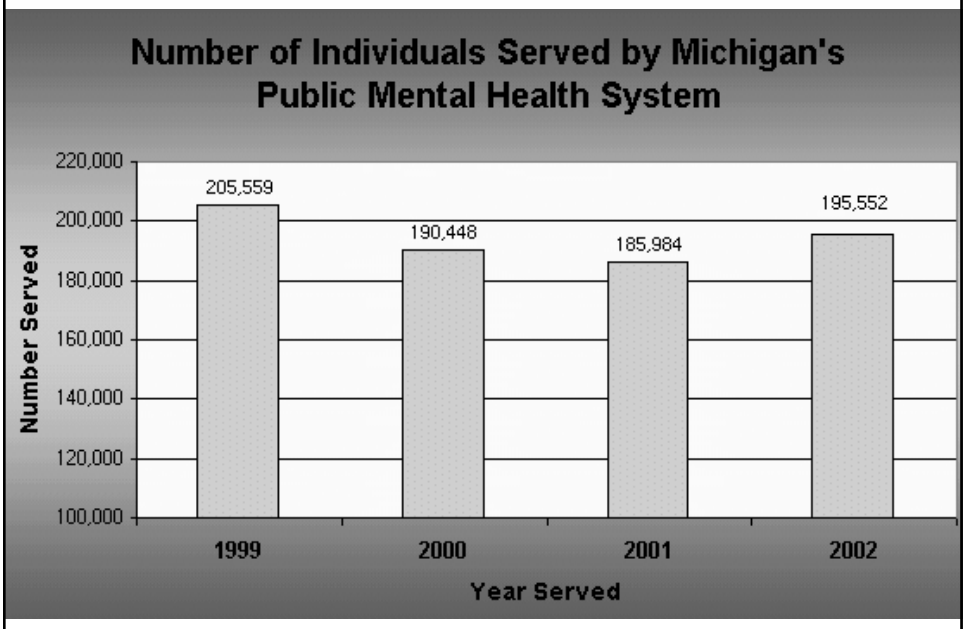
Source: Community Mental Health Services Programs Demographic and Cost Data, FY 1999 - FY2002, November 2003.

Mental Illness: An individual is determined to have mental illness if he/she has a DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability or substance abuse disorder.

Developmental Disability: An individual is determined to have a developmental disability if he/she meets the 1996 Mental Health Code Definition of Developmental Disability, regardless of the types of services that he/she receives.

Dual Diagnosis: During FY2001 and FY2002, CMHSPs were given the option to designate an individual as having a 'dual diagnosis' if he/she met the standards for both mental illness as well as developmental disability.

Note: During FY 1999 through FY 2000, the 'dual diagnosis' category was not applicable.



Source: Community Mental Health Service Programs Demographic and Cost Data, FY 1999–2002, November 2003.

Number of Children and Adults with Mental Illness Served by Michigan's Public Mental Health System

Fiscal Year	Individuals with Mental Illness						Total
	Children		Adults		Age Not Reported		
	N	%	N	%	N	%	
1999	40,998	23.7%	125,814	72.9%	5,885	3.4%	172,697
2000	35,994	23.8%	110,826	73.4%	4,264	2.8%	151,084
2001	29,356	21.6%	101,799	74.9%	4,809	3.5%	135,964
2002	36,732	23.7%	117,174	75.5%	1,394	0.9%	155,300

Source: Community Mental Health Service Programs Demographic and Cost Data, FY1999 - FY2002, November 2003.

Mental Illness: An individual is determined to have mental illness if he/she has a DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability or substance abuse disorder.

Children are those consumers who are 18 years of age or younger during the fiscal year of reporting.

Note: Individuals who were dual eligible during FY '01 or FY '02 are not included in this table.

Number of Children and Adults with a Developmental Disability Served by Michigan's Public Mental Health System

Fiscal Year	Individuals with a Developmental Disability						Total
	Children		Adults		Age Not Reported		
	N	%	N	%	N	%	
1999	4,671	17.7%	21,571	81.6%	193	0.7%	26,435
2000	5,158	17.1%	24,533	81.4%	463	1.5%	30,154
2001	6,259	18.9%	26,561	80.0%	379	1.1%	33,199
2002	4,450	17.3%	20,888	81.2%	387	1.5%	25,725

Source: Community Mental Health Service Programs Demographic and Cost Data, FY1999 - FY2002, November, 2003.

Developmental Disability: An individual is determined to have a developmental disability if he/she meets the 1996 Mental Health Code Definition of Developmental Disability, regardless of the types of services that he/she receives.

Children are those consumers who are 18 years of age or younger during the fiscal year of reporting.

Note: Individuals who were dual eligible during FY '01 or FY '02 are not included in this table.

Number of Children and Adults who are Dual Eligible Served by Michigan's Public Mental Health System

Fiscal Year	Individuals with a Dual Diagnosis						Total
	Children		Adults		Age Not Reported		
	N	%	N	%	N	%	
2001	1,108	18.6%	4,828	81.1%	17	0.3%	5,953
2002	926	14.8%	5,246	83.8%	88	1.4%	6,260

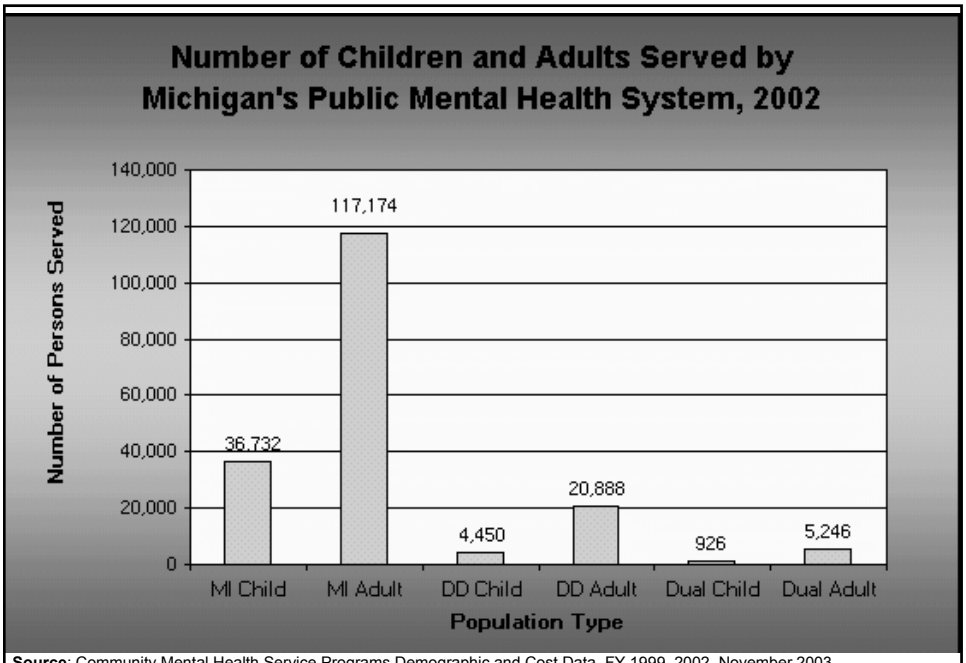
Source : Community Mental Health Service Programs Demographic and Cost Data, FY2001 and FY2002, November 2003.

Note: During FY2001 and FY2002, CMHSPs were given the option to designate an individual as having a 'dual diagnosis' if he/she met the standards for both mental illness as well as developmental disability.

Mental Illness: An individual is determined to have mental illness if he/she has a DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability or substance abuse disorder.

Developmental Disability: An individual is determined to have a developmental disability if he/she meets the 1996 Mental Health Code Definition of Developmental Disability, regardless of the types of services that he/she receives.

Children are those individuals who are 18 years of age or less during the fiscal year of reporting.



Source: Community Mental Health Service Programs Demographic and Cost Data, FY 1999–2002, November 2003.

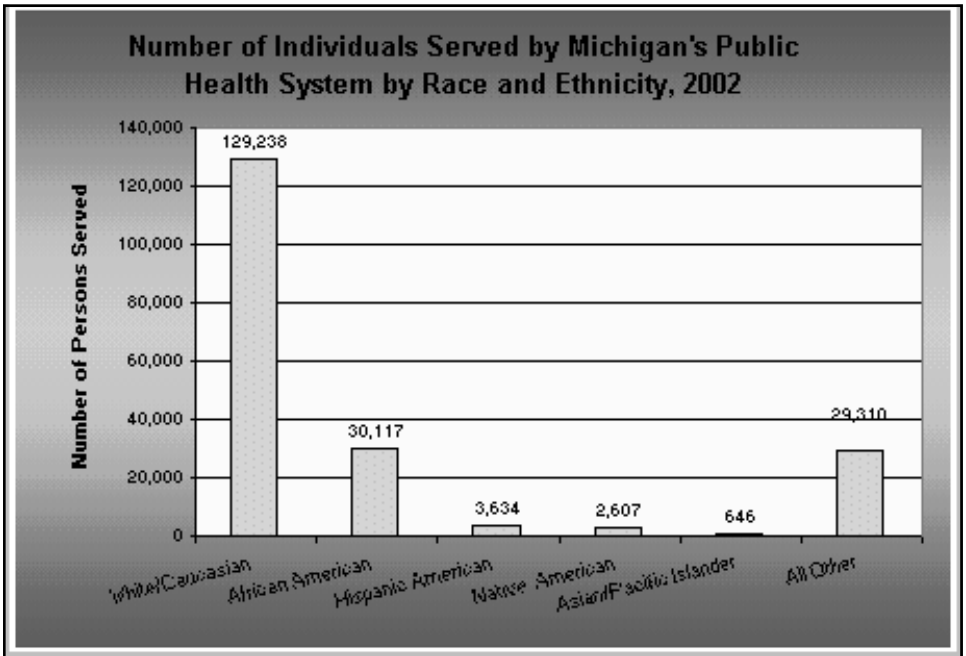
Note: The sum of the counts across categories does not add to the total served as information on age and eligibility designation was not available for some individuals.

Number of Individuals Served by Michigan's Public Mental Health System by Race and Hispanic Ethnicity

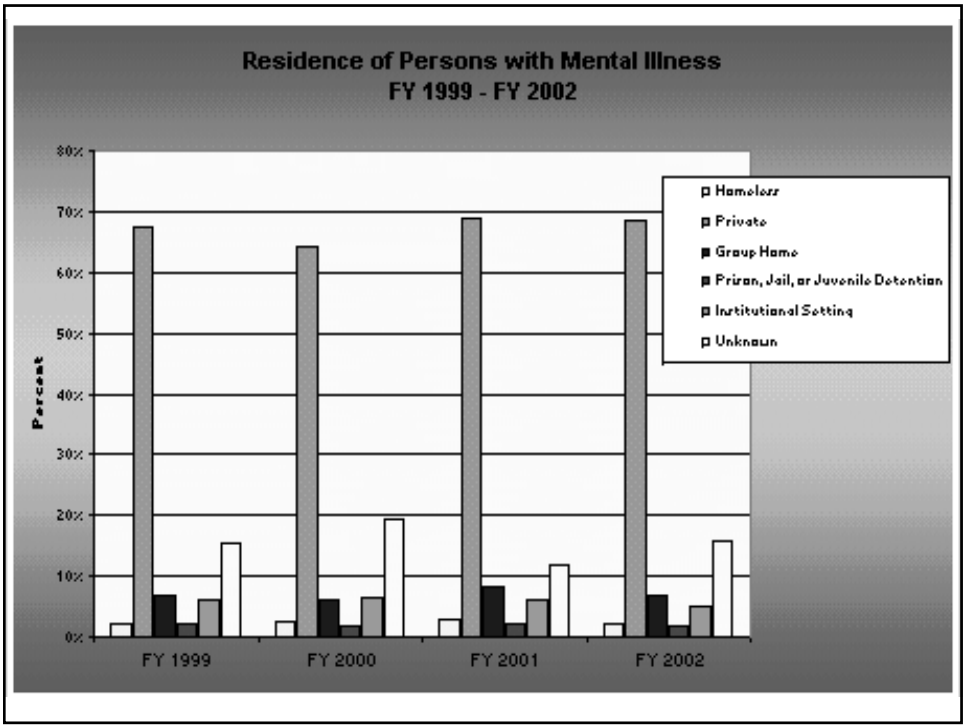
Fiscal Year	White/Caucasian		African American		Hispanic Americans		Native Americans		Asian/Pacific Islander		All Other		Total
	N	%	N	%	N	%	N	%	N	%	N	%	
1999	131,370	63.9%	45,234	22.0%	4,289	2.1%	3,238	1.6%	1,321	0.6%	20,107	9.8%	205,559
2000	125,239	65.8%	34,366	18.0%	3,654	1.9%	2,770	1.5%	842	0.4%	23,537	12.4%	190,408
2001	130,339	72.4%	25,484	14.2%	3,061	1.7%	2,390	1.3%	641	0.4%	18,116	10.1%	180,031
2002	129,238	66.1%	30,117	15.4%	3,634	1.9%	2,607	1.3%	646	0.3%	29,310	15.0%	195,552

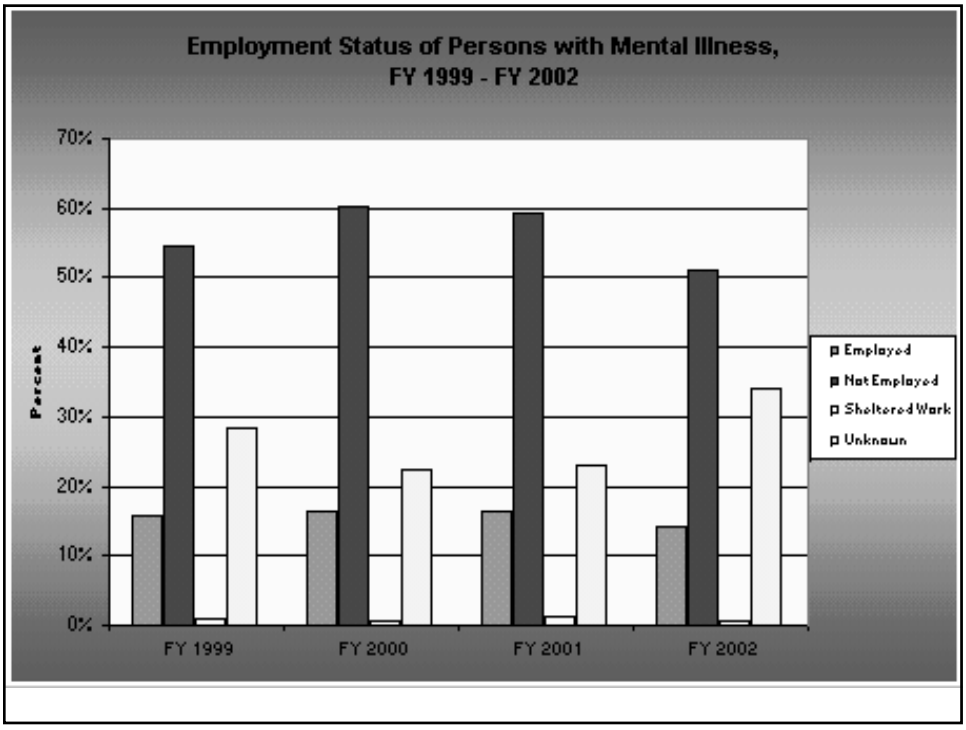
Source: Community Mental Health Service Programs Demographic and Cost Data, FY 1999 - FY2002.

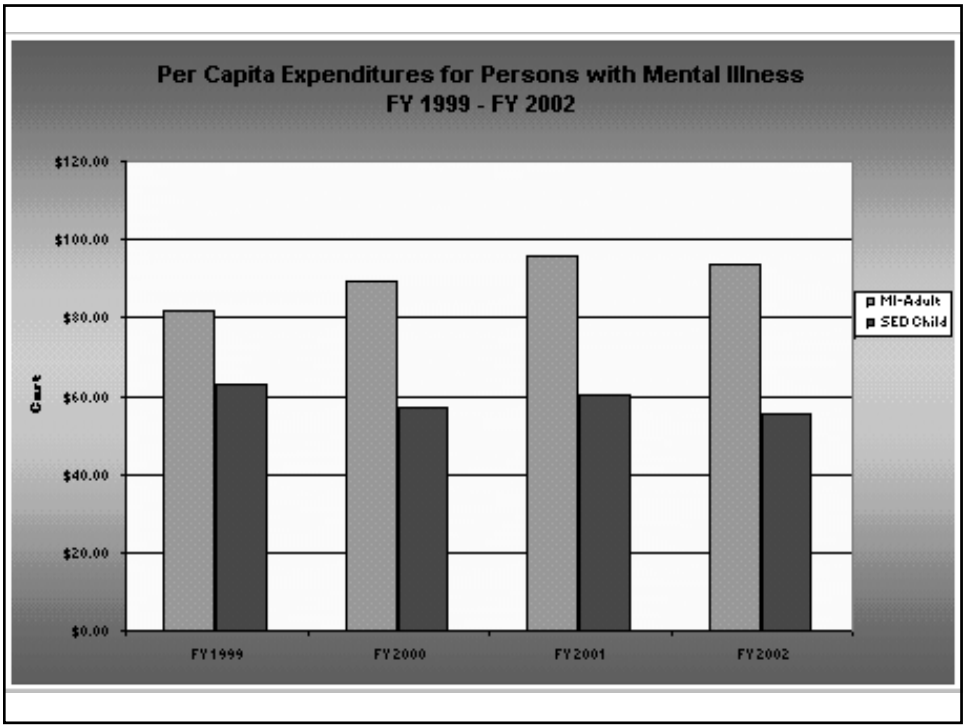
All Others includes Arab-Americans, individuals reporting multiple races, and individuals for whom race and ethnicity information is missing or unknown.

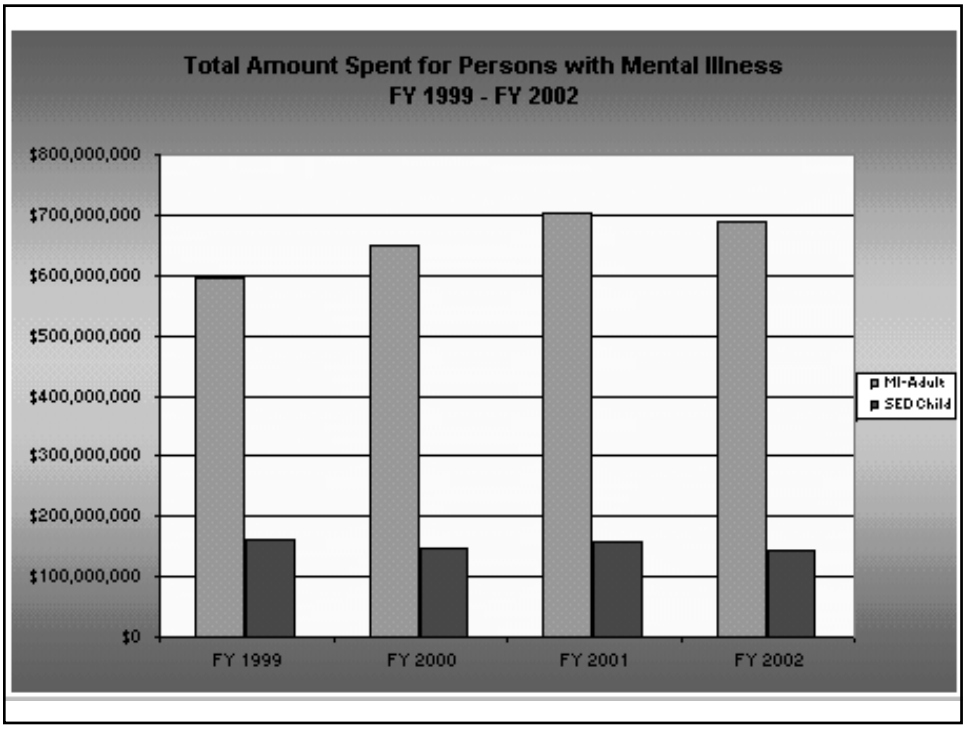


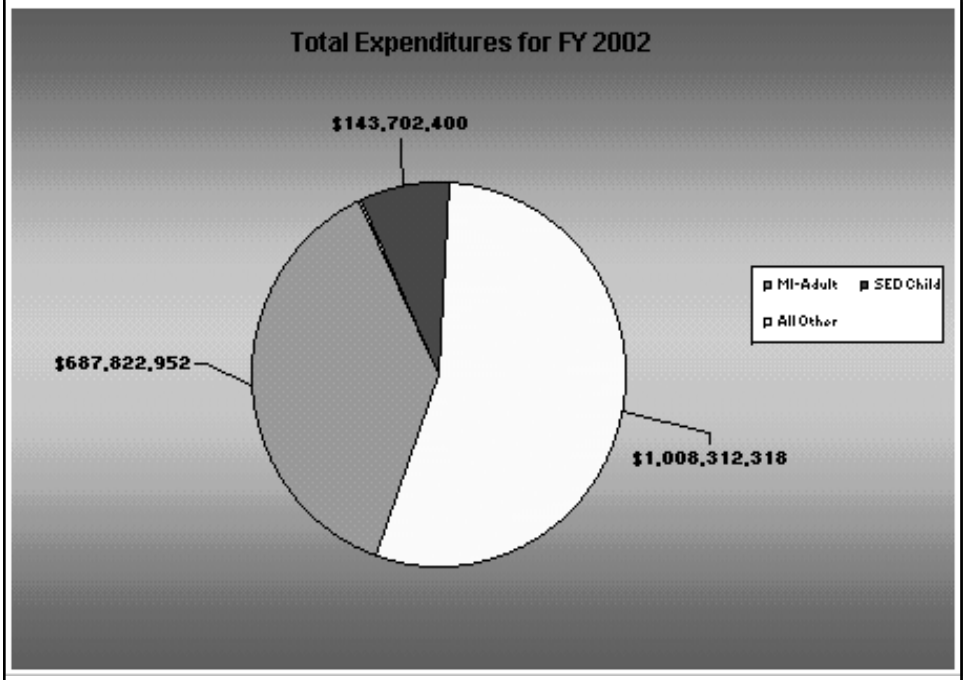
Source: Community Mental Health Service Programs Demographic and Cost Data, FY 1999–2002, November 2003.
All Others: Includes Arab Americans, individuals who are multi-racial and those for whom race and ethnicity information is missing or unknown or those individuals who refused to provide the information.


Residence of Persons with Mental Illness
FY 1999 - FY 2002
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent
FY 1999
FY 2000
FY 2001
FY 2002
Homeless
Private
Group Home
Prison, Jail, or Juvenile Detention
Institutional Setting
Unknown


Employment Status of Persons with Mental Illness,
FY 1999 - FY 2002
70%
60%
50%
40%
30%
20%
10%
0%
Percent
FY 1999
FY 2000
FY 2001
FY 2002
Employed
Not Employed
Sheltered Work
Unknown


Per Capita Expenditures for Persons with Mental Illness
FY 1999 - FY 2002
$120.00
$100.00
$80.00
$60.00
$40.00
$20.00
$0.00
Cost
FY1999
FY2000
FY2001
FY2002
MI-Adult
SED Child


Total Amount Spent for Persons with Mental Illness
FY 1999 - FY 2002
$800,000,000
$700,000,000
$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
FY 1999
FY 2000
FY 2001
FY 2002
MI-Adult
SED Child



Key tensions

- Bold plan *vs.* realistic objectives
- Federal/state leadership *vs.* local initiatives
- Science/evidence *vs.* practice/policy
- Prescriptive treatments *vs.* outcomes evaluation

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Key tensions

- Deliberate scientific evaluation *vs.* swift political action
- Insider *vs.* outsider perspectives
- Targeted populations *vs.* integrated perspectives
- Coordinated programs *vs.* entrepreneurial solutions

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Results of commissioner survey

- Common themes:
  - High-quality, effective services
  - Service delivery and access
  - System structure
  - Funding/financing

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Results of commissioner survey

- Least understood issues:
  - System access and fragmentation
  - Who the system serves
  - Funding/financing
  - Mental illness diagnosis, treatment, prevention

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Lunch

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Proposed guiding principles

1. Consumer and other stakeholder acceptability
2. Person-centered
3. Mental health *vs.* mental illness, with a focus on recovery
4. Improved quality, outcomes, satisfaction
5. Equal access to an appropriate array of services
6. Effective use of resources

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Framework for deliberations

- High-quality, effective services
- Service delivery and access
- Organization/structure
- Funding

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Small group dialogue

- Is anything missing from the principles?
- What refinements would you recommend?
- Will the framework serve as a useful tool for organizing our deliberations?
- Can it be strengthened?

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Small groups report out

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Planning for next meeting

- Monday, March 1, 8:30 A.M. – 4:00 P.M.
  - Meeting location?
  - Dates, locations for public hearings
  - Meeting goal
- Travel planning, expense reimbursement protocol
- Point(s) of commissioner contact

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Public comment

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Adjourn

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